

**Becket Systems**  
**An Independent Review Organization**  
**815-A Brazos St #499**  
**Austin, TX 78701**  
**Phone: (512) 553-0360**  
**Fax: (207) 470-1075**  
**Email: manager@becketystems.com**

**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE NOTICE SENT TO ALL PARTIES:** Jul/05/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** outpatient EMG of the left upper extremity

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic Surgeon

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)  
☐ Overturned (Disagree)  
☐ Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** The reviewer finds that the clinical documentation does not support the medical necessity for the requested outpatient EMG of the left upper extremity per guideline recommendations, the prior denials are upheld.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
01/27/11 – Clinical Note –MD  
01/27/11 – Radiographs Left Shoulder  
01/27/11 – Radiographs Lumbar Spine  
02/01/11 – Clinical Note –MD  
02/10/11 – Physical Therapy Note  
02/15/11 – Clinical Note – Illegible Signature  
02/22/11 – Physical Therapy Note  
02/23/11 – Physical Therapy Note  
02/25/11 – Physical Therapy Note  
02/28/11 – Physical Therapy Note  
03/01/11 – Clinical Note –MD  
03/09/11 – Mri Left Shoulder  
03/15/11 – Clinical Note MD  
03/16/11 – Physical Therapy Note  
03/21/11 – Physical Therapy Note  
03/23/11 – Notice Of Disputed Issue(S) And Refusal To Pay Benefits  
03/30/11 – Clinical Note –MD  
04/20/11 – Clinical Note –MD  
04/20/11 – Radiographs Left Shoulder  
04/22/11 – Clinical Note –MD  
05/04/11 – Electrodiagnostic Studies  
05/11/11 – Clinical Note –MD  
05/13/11 – Clinical Note –MD  
05/13/11 – Radiographs Cervical Spine

06/02/11 – Mri Cervical Spine  
06/15/11 – Clinical Note –MD  
06/22/11 – Clinical Note –CFNP  
06/28/11 – Clinical Note –MD  
06/29/11 – Mri Lumbar Spine  
07/07/11 – Clinical Note –MD  
07/07/11 – Notice Of Disputed Issue(S) And Refusal To Pay Benefits  
08/09/11 – Clinical Note –CFNP  
09/09/11 – Clinical Note –MD  
09/12/11 – Clinical Note –MD  
09/29/11 – Clinical Note –MD  
09/29/11 – Operative Report  
10/17/11 – Clinical Note –MD  
11/01/11 – Physical Therapy Note  
11/03/11 – Physical Therapy Note  
11/04/11 – Physical Therapy Note  
11/07/11 – Physical Therapy Note  
11/23/11 – Physical Therapy Note  
11/28/11 – Physical Therapy Note  
12/07/11 – Physical Therapy Note  
12/09/11 – Physical Therapy Note  
12/12/11 – Physical Therapy Note  
12/14/11 – Physical Therapy Note  
12/16/11 – Physical Therapy Note  
12/19/11 – Physical Therapy Note  
12/28/11 – Clinical Note –Np-C  
01/04/12 – Notice Of Disputed Issue(S) And Refusal To Pay Benefits  
01/12/12 – Physical Therapy Note  
01/17/12 – Physical Therapy Note  
01/19/12 – Physical Therapy Note  
01/24/12 – Physical Therapy Note  
01/30/12 – Physical Therapy Note  
02/07/12 – Physical Therapy Note  
02/08/12 – Physical Therapy Note  
02/14/12 – Physical Therapy Note  
02/16/12 – Physical Therapy Note  
02/23/12 – Clinical Note –Np-C  
03/22/12 – Clinical Note –MD  
03/29/12 – Clinical Note –MD  
04/12/12 – Clinical Note –MD  
04/26/12 – Clinical Note –MD  
05/10/12 – Clinical Note –MD  
05/14/12 – Clinical Note –MD  
05/24/12 – Clinical Note –MD  
05/24/12 – Notice Of Utilization Review Findings  
06/05/12 – Notice Of Utilization Review Findings  
06/07/12 – Clinical Note –MD  
06/08/12 – Notice Of Utilization Review Findings  
06/12/12 – Notice Of Utilization Review Findings  
06/14/12 – Request For Review By Independent Review Organization

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who sustained an injury in xx/xx when a cabinet fell on her. Radiographs of the lumbar spine performed 01/27/11 revealed no anterolisthesis or retrolisthesis. There was a small amount of osteophytic spurring at L4 and L5. Electrodiagnostic studies performed 05/04/11 revealed no evidence of entrapment neuropathy, plexopathy, or radiculopathy of the left upper extremity. Radiographs of the cervical spine performed 05/13/11 revealed thinning of the intervertebral disc space between C5-6 and C6-7 with anterior and posterior osteophytic spurring. There was decreased cervical lordosis. MRI of the cervical spine performed 06/02/11 revealed desiccation at C5-6 with a 2mm

posterocentral annular disc bulge. There was bilateral uncovertebral hypertrophic changes and bilateral foraminal stenosis, left greater than right. At C6-7, there was a 1mm posterocentral annular disc bulge.

The claimant underwent diagnostic arthroscopy with debridement, partial synovectomy, chondroplasty, arthroscopic stabilization, subacromial decompression/acromioplasty, and open Mumford procedure on 09/29/11. The claimant saw Dr. on 10/17/11. Physical exam revealed tenderness to palpation over the left acromioclavicular joint, anterior glenohumeral joint, and anterior subacromial space. Left shoulder range of motion was limited. Neer's, Hawkin's, and O'Brien's were negative. There were well-healed surgical incisions noted. The claimant was recommended for physical therapy. The claimant completed 21 sessions of physical therapy from 11/01/11 through 02/16/12.

The claimant saw Dr. on 05/14/12 with complaints of pinching and pain to the lateral aspect of the left shoulder. The claimant reported burning that radiated into the shoulder and down into the hand. Physical exam revealed well-healed portal incisions. There was tenderness along the left paraspinal muscles. There were multiple trigger points noted. There was no muscular atrophy. There was normal rotator cuff strength. Drop arm was persistently positive. Sensation was intact, but the claimant described paresthesias. Spurling's was negative. The claimant was recommended for electrodiagnostic studies of the left upper extremity. The request for outpatient EMG of the left upper extremity was denied by utilization review on 05/24/12 due to no indication of any neurological dysfunction or possible radiculopathy on the physical examination. The request for outpatient EMG of the left upper extremity was denied by utilization review on 06/08/12 due to no indication of any neurological dysfunction or possible radiculopathy on the physical examination.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The claimant has undergone prior EMG/NCV studies of the upper extremities that were normal. The claimant's most recent physical exams did not reveal any significant neurological deficits that would support further diagnostic testing for radiculopathy such as EMG studies. As such the reviewer finds that the clinical documentation does not support the medical necessity for the requested outpatient EMG of the left upper extremity per guideline recommendations, the prior denials are upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)